DOCUMENT RESUME

ED 209 702 CS 503 656

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TITLE Communication and Gerontology: Health Communication Training for Providers of Health Services to the Elderly.
PUB DATE Jul 81
NOTE 18p.; Paper presented at the Meeting of the Speech Communication Association Summer Conference on Communication and Gerontology (Edwardsville, IL, July 22-24, 1981). May not reproduce well due to broken print.

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Career Education; *Communication Problems; Course Content; *Geriatrics; Gerontology; *Health Personnel; Higher Education; Older Adults; Speech Communication; Speech Curriculum

ABSTRACT

Since the elderly are a significant population of health care consumers, health care professionals should be trained to deliver health services to them as effectively and humanely as possible. While the primary tool for delivery of health care services to people is human communication, there is evidence that the communication between the providers and consumers of health care is in need of improvement. Researchers advocate the development of educational programs, such as a health communication course, that will help prepare people for occupations that deal with the problems and concerns of the elderly. Ten primary topics for study in such a course relate to the specific communication needs of the elderly: (1) the relationships between health care and human communication, (2) the use of language in the delivery of health care, (3) the importance of nonverbal communication in health care, (4) health care interviewing, (5) therapeutic communication in psychological and emotional areas, (6) group communication in health care, (7) the role of conflict in health care delivery, (8) intercultural communication in health care, (9) communication in medical organizations, and (10) communication with the terminally ill. By offering strategies for improving communication in health care, perhaps at least some situations that might be problematic will be handled more sensitively and effectively by communication trained health care professionals. (HTH)

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Communication and Gerontology:

Health Communication Training for Providers of Health Services to the Elderly

by

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One of the largest populations of consumers of health care services is the elderly. (Although there is a serious problem in exactly defining the population of "elderly" people since chronological age may not be the best determinant of aging, the population I am referring to here includes all of those people over the age of 65 years).[1] As people grow older they become increasingly concerned about their physical and mental health, leading to increased seeking of health care services by the elderly. In 1977 the U.S. Department of Health, Education, and Welfare reported that age was one of the most important population characteristics in identifying the groups of people seeking health care treatment in the United States;

> Age is one of the characteristics which can be used to predict health status and judge the need for health services. In general, older people are less healthy and tend to utilize health services more frequently than younger ones. Approximately 10 percent of the U.S. population is 65 years of age or older and approximately 4 percent is 75 or older. In areas where there is high in-migration of retired persons or high out-migration of young people, these proportions may be much higher. In these areas there are likely to be higher death rates, greater prevalence of chronic conditions and greater utilization of health services, especially long-term care services.[2]

Since the elderly are a significant population of health care consumers health care professionals should be trained to deliver health services to the elderly as effectively and as humanely as possible.

The primary tool for the delivery of health care services to people is human communication.[3] The diagnosis, education, and treatment of health problems is accomplished through the establishment and

maintenance of communication relationships between the providers and consumers of health care services. There is abundant evidence that the communication between the providers and consumers of health care is in need of improvement.[4] Equally obvious is the inadequate, and often inhumane treatment of the elderly in the health care system.[5] It is my contention that many of the problems the elderly face in receiving health care services is strongly related to problems in health care communication. These health communication problems occur between the health care provider and the consumer, as well as between members of the health care team. I advocate training the providers of health care services in effective and sensitive methods of human communication.[6] An important aspect of communication training for health care professionals would include examination of the special communicative needs of the elderly in the delivery of health care services.

Peterson and Bolton advocate the development of educational programs in higher education that will help prepare people for occupations that deal with the problems and concerns of the elderly.[7] Since health care professionals are in occupations that deal with the problems and concerns of the elderly on an everyday basis they are an ideal population to educate about the older person. Additionally, since health care services are delivered through the use of human communication, there is a need to combine gerontology education and communication education for the health care practitioner. Gerontology education will help the health care professional to better understand the elderly

through acquizition of reliable information about the older individual and increased sensitization to the needs of the older population. Communication education will help the health care professional better relate his/her knowledge about the elderly and their health problems to the practice of health care delivery.

One way to combine aspects of gerontology education and communication education for the health care professional is in a college course in health communication. Health communication is a relatively new but growing area of communication education in institutions of higher education.[8] "Health communication is an area of study concerned with the role of human interaction in the health care process."[9] By focusing on the communicative demands of health care the health care professional is motivated to recognize the importance of his/her interaction with patients and colleagues, as well as to develop effective human communication skills.

In the remainder of this paper I will describe some of the primary topics of study in health communication and relate these topics to the specific communicative needs of the elderly. There are ten primary topic areas that I concentrate on in teaching health communication. These topic areas are not exhaustive in the area of health communication; they concentrate on the human communication aspects of health care delivery, as opposed to media communication approaches to health communication. Additionally, the topics are not always mutually exclusive, but interrelate in many different ways. The common thread that holds the different topic areas together is the use of human interaction to elicit understanding between peoples, coordinate human activities, and evoke cooperation in health care.

The first topic of study in health communication is examining the relationships between health care and human communication. Human communication is established as the primary delivery system for health care services and examples of how health care professionals depend on their abilities to communicate are discussed. "For example, the doctor who interviews a new patient to establish an accurate medical history, the dentist who probes a patient's mouth to discover the source of a patient's toothache, and the pharmacist who describes the use of a prescribed drug to a customer, are all depending on their ability to communicate effectively to these health care clients to accomplish their professional tasks."[10]

Current problems in health care delivery are related to underlying problems in human communication. Many of these problems are particularly relevant to the problems in health care encountered by the elderly. Some of these problems include dehumanization of patients by health care professionals, lack of patient compliance with health care regimens and appointments, misunderstandings between patients and practitioners, cultural barriers between people in health care, and widespread dissatisfaction with the helper-helpee relationship by both patients and practitioners.[11] The development of the patient-practitioner relationship is analyzed as a possible cause for these health care problems and a potential tool for alleviating the problems. Additionally, theoretical bases of human communication and perception are examined and related to the delivery of health care services.

The second topic of study is the use of language in the delivery of health care.[12] The functions and abuses of medical jargon are examined. Public speaking and patient education skills are practiced, as well as the development of effective listening skills. Students develop the ability to explain and describe complex concepts and procedures to lay audiences. Often patients do not have the understanding of health care procedures and consequences to make informed decisions about their treatment. It is stressed that it is the responsibility of the health care practitioner to provide the patient with sufficient information to allow the patient to make a knowledgeable decision about treatment through informed consent.[13] Cultural aspects of language and language usage are discussed as well.

The third topic of discussion is the importance of nonverbal communication in health care. Sensitivity to the range of nonverbal cues being sent by both the patient and the practitioner are examined. The impact of nonverbal communication on the emotional reactions of the patient to the health care situation is emphasized.[14] Human touch has been found to be an important form of therapeutic communication in geriatric nursing.[15] Unfortunately research has also shown that those elderly residents most in need of therapeutic touches were often going untouched due to cultural barriers, sex taboos and the social structure of the health care organizations.[16]

The fourth topic of study is health care interviewing methods. The goals and responsibilities of health care interviewing is examined.

The importance of establishing rapport is stressed as a crucial step to effective patient interviewing. Students are taught to become sensitive to the perspective of the patient by allowing the patient to describe as fully as possible their own perceptions of their health care problem. A problem in much health care interviewing is jumping to conclusions about the patient's condition without allowing the patient to "tell his story" about why he is seeking health care.[17] Different interview questioning formats and techniques are also explored.

The fifth topic of study is therapeutic communication. Psychological and emotional aspects of illness are discussed and related to patient practioner communication.[18] Self-disclosure and trust are examined as crucial ingredients in the development of therapeutic relationships. Empathy is analyzed and students are encouraged to develop skills in becoming empathic helpers.[19] The importance of establishing person to person rather than person to object relationships is stressed.

The sixth area of study is group communication in health care. The use of health care teams in the delivery of modern medical services is examined.[20] The family group is examined as a source of health care for members. The family is examined in relation to placing elderly family members in long-term care centers. The extended-family model is compared to current nuclear models of family life and related to geriatric health care implications.[21] Group therapy and problem solving is also discussed in relation to health care.

The seventh area of study is the role of conflict in health care delivery. Intrapersonal conflict is related to the frustrations health care professionals encounter in attempting to integrate their personal and professional roles. Patient dissonance is also explored in relation to the powerlessness that is often felt in relation to the treatment and control of their health care problems. Mechanisms for coping with anger and frustrations are examined and related to the need for assertive communication in developing viable personal and interpersonal conflict strategies and tactics.[22]

The eighth topic of investigation is intercultural communication in health care. Interprofessional relations between different members of the health care team is examined. Male and female cultural roles are analyzed and related to the professional roles of doctors and nurses.[23] The cultural role of the patient is explored and related to feelings of dehumanization and stigma.[24] The elderly are often treated as though they were children by health care practitioners serving to alienate and dehumanize them. Problems with stereotyping people are discussed and related to patient treatment.[25] Sensitivity to cultural differences is fostered through discussion of the commonalities of different people seeking health care. Carmichael comments, "The most significant intrapersonal problems of the aged may well be the effects that aging related attitudes, values, and beliefs have on the aging process."[26] Through examination of culturally held beliefs, values, and attitudes health professionals can begin developing awareness of cultural biases against the elderly and eliminate non-productive stereotypes.

The ninth topic area is communication in medical organizations. Medical organizations tend to be among the most bureaucratic, with many rules, regulations, and officials.[27] The importance of accurate and timely information in health care organizations is stressed. Formal and informal communication networks are identified and related to the effective management of complex medical organizations. Medical organizations and gerontology are closely related because of the large number of older people living in health care institutions such as geriatric centers, hospitals for the chronically ill, nursing homes and rehabilitation hospitals. In fact, in 1974 the National Center for Health Statistics reported that almost 1.2 million elderly people were residing in nursing home isnstitutions.[28] A recent study of the communication patterns of the elderly in a retirement community has indicated that residents of the community develop mutually therapeutic communication relationships that provide health care benefits to members of the organization.[29] Further examination of the quality and patterns of communication in health care organizations may provide useful information for improving organizational life for long-term patients.

The final area of study is communication with the terminally ill. The communicative needs of the dying are explored.[30] Cultural perspectives on death and the dying process are examined and demystified. Problems in current health care for the terminally ill are related to communication. Students are encouraged to recognize their own mortality to help them develop empathy with the dying. The importance of allowing the dying

person prepare emotionally for death, and to die with dignity is stressed.[31] The topic area of communication with the terminally ill is, perhaps, the area of health communication that most closely interfaces with gerontology, because the older person is more acutely aware of his/her mortality. Sensitivity and respect for the dying person is crucial in establishing effective communication. Many of the topics discussed in earlier sections of the course can be applied to the communication relationship between the dying person and the health care provider. Empathy, listening skills, sensitivity to nonverbal cues, and honest communication are necessary interaction skills for the health practitioner attempting to help the dying person make a satisfying transition from life to death.

Certainly one course in health communication will not solve the variety of communication problems facing people in the health care system. By making people aware of many of these problems, however, and offering strategies for improving communication in health care, perhaps some situations that might be problematic and therefore painful to patients and practitioners will be handled more sensitively and effectively by communication trained professionals. Additionally, "As people become older and more frail, their increasing ill-health may be aggravated by problems of isolation, unsatisfactory accomodation and inadequate means. All these are likely to affect their relationship with their general practitioner."[32] The combination of communication and gerontology education in health communication courses can help the health care practitioner develop effective communication relationships with elderly patients and thereby help ease the health care problems faced by the aged.

FOOTNOTES

[1] Janice Schuetz, "Lifelong Learning: Communication Education for the Elderly," Communication Education 29 (1980), p. 34. See also, Margaret Huyck, Growing Older (Englewood Cliffs, N.J.: Prentice Hall, 1974), ch. 1.

[2] U.S. Department of Health, Education, and Welfare Papers On the National Health Guidelines: Baselines for Setting Health Goals and Standards (Washington: DHEW Publication No. (HRA) 77-640, January, 1977), p. 53.

[3] Gary L. Kreps, "Health Communication Education for Future Health Practitioners," Health Communication Newsletter 7 (1980), 6-8. See also, Donald Cassata, "Health Communication Theory and Research: A Definitional Overview," in D. Nimmo, ed., Communication Yearbook 4 (New Brunswick, N.J.: Transaction - International Communication Association, 1980), 583-589.

[4] Harold L. Walker, "Communication and the American Health Care Problem," Journal of Communication 23 (1973), 349-360. See also, Barbara Korsch and Vida Negrete, "Doctor-Patient Communication," Scientific American 227 (1972), 66-74.

[5] U.S. Senate Special Committee on Aging, Subcommittee On Long Term Care, Nursing Home Care in the United States, Failure in Public Policy: Introductory Report (Washington: U.S. GPO, 1974). See also, U.S. Senate Special Committee on Aging, Subcommittee On Long Term Care, Nursing Home Care in the United States, Failure in Public Policy: Introductory Report and Nine Supporting Papers (Washington: U.S. GPO, 1975). See also,

M. Mendelson, Tender Loving Greed (New York: Knops, 1974).

6 Kreps, "Health Co. Ed. ...."

7 David A. Peterson and Christopher R. Bolton, Gerontology Instruction in Higher Education (New York: Springer Publishing Co., 1980).

8 Gary L. Kreps, "Communication Education in the Future: The Emerging Area of Health Communication," paper presented at the Central States Speech Association convention, 1981, also in Resources in Education (in-press, 1981).

9 Ibid., p. 7.

10 Ibid.

11 For a discussion of dehumanization of patients in health care see: William Gaylin, Caring (New York: Knopf, 1976). Also, P. Langlois, "Helping Patients Cope With Hospitalization," Nursing Outlook 19 (1971), 334-36. Also, Anonymous, "A Consumer Speaks Out About Hospital Care," American Journal of Nursing 76 (1976), 1443-44. For a discussion of compliance in health care see, Anthony Komaroff, "The Practitioner and the Compliant Patient," American Journal of Public Health 66 (1976), 833-35. Also, R. Gillum and A. Barsky, "Diagnosis and Management of Patient Noncompliance," Journal of the American Medical Association 228 (1974), 1563-67. Also, Joy Frelinger and Gary L. Kreps, "Patient Compliance and Personalized Physician-Patient Communication Relationships," unpublished paper, University of Southern California, 1977. For a discussion of misunderstandings in health care see, J. Golden and G. Johnson. "Problems

of Distortion in Doctor-Patient Communications," Psychiatry in Medicine 1 (1970), 127-49. Also, E. Cassell and L. Skopek, "Language as a Tool in Medicine: Methodology and Theoretical Framework," Journal of Medical Education 52 (1977), 197-203. Also, C. Boyle, "Difference Between Patients' and Doctors' Interpretations of Some Common Medical Terms," British Medical Journal 22 (1970) 286-89. For a discussion of cultural barriers in health care see, E. Friedson, "Disability as Deviance," in M. Sussman, ed., Sociology and Rehabilitation (Washington: American Sociological Association, 1966). Also, Dean C. Barnlund, "The Mystification of Meaning: Doctor-Patient Encounters," Journal of Medical Education 51 (1976), 716-25. Also, L. Lynch, ed., The Cross Cultural Approach to Health Behavior (Rutherford, N.J.: Farleigh Dickinson University Press, 1969). For a discussion of dissatisfaction in health care see, Korsch and Negrete, "Doctor-Patient Communication." Also, Z. Ben-Sira, "The Function of the Professionals Affective Behavior in Client Satisfaction: A Revised Approach to Socail Interaction Theory," Journal of Health and Social Behavior 17 (1976), 3-11.

12 Nicholas C. Chriss, "Doctors Down the Logorrhea," Los Angeles Times (July 17, 1977), 1-3,4. See also, Barnlund, "The Mystification of Meaning ...." Also, Golden and Johnson, "Problems of Distortion...."

13 R. Alfidi, "Informed Consent: A Study of Patient Reaction," Journal of the American Medical Association 216 (1971), 1325. Also, J. Horty, "Informed Consent: New Rule Puts Burden of Proof On Patient," Modern Hospital 74 (1971), 116.

[14] For a discussion of the range of nonverbal behaviors and how they can be used to cause or alleviate patient fears see, Gary L. Kreps, "Nonverbal Communication in Dentistry," Dental Assistant 50 (1981), 18-20.

[15] Wilbur A. Watson, "The Meanings of Touch: Geriatric Nursing," Journal of Communication 25 (1975), 104-112. Also see, C. Rinck, "Interpersonal Touch Among Residents of Homes for the Elderly," Journal of Communication 30 (1980), 44-47.

[16] Watson, "The Meanings of Touch...."

[17] M. Wexler and L. Adler, Help the Patient Tell His Story (Oradel, N.J.: Medical Economics Books, 1971). Also, M. Bloom, "Interviewing the Ill Aged," The Gerontologist 11 (1971), 292-99. Also, A. Eustene, "Explaining to the Patient: A Therapeutic Tool and a Professional Obligation," Journal of the American Medical Association 165 (1957), 1110.

[18] An excellent discussion of the symbolic aspects of illness appears in, Barnlund, "The Mystification of Meaning ...."

[19] R. Katz, Empathy: Its Nature and Uses (Glencoe, Il.: The Free Press, 1963). See also, E. Stotland, et al., Empathy, Fantasy, and Helping (Beverly Hills: Sage Publications, 1978). Also, C. Truax, "Therapist Empathy, Genuineness, and Warmth and Patient Therapeutic Outcome," Journal of Consulting Psychology 30 (1966), 395-401. Also, C. Truax, "The Meaning and Reliability of Accurate Empathy: A Rejoinder," Psychological Bulletin 77 (1972), 397-99.

[20] Barbara C. Thornton, "Health Care Teams and Multimethodological Research," In B. Ruben, ed., Communication Yearbook 2 (New Brunswick, N.J.: Transaction - International Communication Association, 1978), 538-53.

[21] G. Spark and E. Brody, "The Aged As Family Members," Family Process 9 (1970), 195-210. Also, E. Shanas and G. Streib, eds., Social Structure and the Family: Generational Relations (Englewood Cliffs, N.J.: Prentice Hall, 1965). Alsom G. Streib, "Family Patterns in Retirement," Journal of Social Issues 14 (1958), 46-60.

[22] Joyce Frost and William Wilmot, Interpersonal Conflict (Dubuque, Iowa: William C. Brown Company, 1978).

[23] G. Corea, The Hidden Malpractice: How American Medicine Treats Women as Patients and Professionals (New York, William Morrow, 1977). Also see, Sandra Bem, and Daryl Bem, "Case Study of a Nonconscious Ideology: Training the Woman to Know Her Place," in Daryl Bem, Beliefs, Attitudes and Human Affairs (New York, Wadsworth, 1970), 89-99.

[24] Erving Goffman, Stigma: Notes on the Management of Spoiled Identity (Englewood Cliffs, N.J.: Prentice Hall, 1963). Also see, Friedson, "Disability as Deviance ...."

[25] Beth Hess, "Stereotype of the Aged," Journal of Communication 24 (1974), 74-84.

[26] Carl W. Carmichael, "Communication and Gerontology: Interfacing Disciplines," Western Speech Communication 40 (1976), p. 123.

[27] Robert House, "Role Conflict and Multiple Authority in Complex Organizations," California Management Review 12 (1970), 53-60. See also, B. Georgopoulos, ed., Organization Research on Health Institutions (Ann Arbor, Mich.: Institute for Social Research, 1974). Also, B. Georgopoulos, Hospital Organization Research: Review and Source Book (Philadelphia: Saunders, 1975). Also, Harish C. Jain, "Supervisory Communication Effectiveness and Performance in Two Urban Hospitals," Personnel Journal 50 (1971), 392-95.

[28] National Center for Health Statistics, Monthly Vital Statistics (1974). Also see, Elaine Brody, Long Term Care of Older People (New York, Human Sciences Press, 1977), p. 35.

[29] Deanne Honeyman-Goodman, "A Study of the Communication Patterns of an Aged Ethnic Population: The Old Jews of Venice, California," unpublished doctoral dissertation in-progress, University of Southern California, 1981.

[30] Elizabeth Kubler Ross, On Death and Dying (New York: MacMillan, 1969). Also see, Austin Kutscher and Michael Goldberg, eds., Caring for the Dying Patient and His Family (New York: Health Sciences Publishing, 1973). Also see, Larry Bugen, ed., Death and Dying (Dubuque, Iowa: William C. Brown, 1979). Also see, Barney Glaser and Anselm Strauss, Awareness of Dying (Chicago, Aldine, 1965).

[31] Barney Glaser, "The Physician and the Dying Patient," Medical Opinion and Review 1 (1965), 108-14. See also, W. Bowers, Counseling the Dying (New York: Thomas Nelson and Sons, 1964). Also see, William Alvarez, "Care of the Dying," Journal of the American Medical Association 2 (1952), 86-91.

[32] Ann Cartwright, Patients and Their Doctors (London, Routledge, 1967), p. 195.